TOWN OF DAVIE
MEDICAL RETURN TO WORK EVALUATION

The treating PHYSICIAN must complete this type form EACH time an injured employee is treated.

Patient/Employee Name: _____ **Date:** _____

Work/Job Position: _____ **Date of Injury:** _____

Employees Department & Division: _____

TO BE COMPLETED BY PHYSICIAN

1). Is this employee able to perform his/her regular work without restriction? ☐ **Yes** ☐ **No**
(If NO Complete #2)

If Yes, Indicate date able to resume regular work assignment: _____

2). Is the employee able to perform any Light work? ☐ **Yes** ☐ **No**

If yes, check the workplace limitations below that are due to the injury .

Hours a Day: _____ **or Full-Time:** _____

Type Work	Full Restriction	Partial Restriction	No Restriction
Sedentary - Lifting 0 - 10 Pounds			
Light - Lifting 10 - 20 Pounds			
Moderate - Lifting 20 - 50 Pounds			
Heavy - Lifting 50 - 100 Pounds			
Pulling / Pushing, Carrying			
Reaching or Working Above Shoulder			
Walking			
Standing			
Sitting			
Stooping			
Kneeling			
Repeated Bending			
Climbing			
Operating a Vehicle, Riding Mower, Tractor, Etc.			

Exposure Limitations: ☐ **Heat** ☐ **Cold** ☐ **Stress** ☐ **Dust** ☐ **Fumes**

3). Period of Disability (Estimated)	**Date Able To Resume Work (Mo., Day, Year)**
Total Disability: From _____ **To** _____	**Light Work** _____ **Employee Advised?** _____
Partial Disability: From _____ **To** _____	**Regular Work** _____ **Employee Advised?** _____

4). Diagnosis Of Injury, Treatment Plan, and Prognosis: _____

_____

_____

Date of Exam: _____ **Next Appointment:** _____ **Has Employee Reached MMI?** _____

Discharged? _____ **Permanent Impairment Rating:** _____**%** **Does Rating Apply to ALL Body Areas?** _____

Physicians Signature: _____ **Date:** _____

Printed Name: _____ **Clinic Name:** _____

Fax Completed form to: (954) 797-1079